Mount Sinai

MEDICAL CENTER

June 17, 2019

Linda D. Smith Associate Regional Administrator Division of Survey & Certification Department of Health & Human Services Centers for Medicare & Medicaid Services 61 Forsyth Street SW, Suite 4T20 Atlanta, Georgia 30303-8909

RE: CMS Certification Number (CCN) 10-0034

Dear Ms. Smith.

We are in receipt of your correspondence dated June 10, 2019 outlining the results of the survey that was conducted at Mount Sinai Medical Center on June 4, 2019.

Enclosed you will find the Action Plan we have developed in order to correct the deficiencies found in the COPs for 42 CFR 482.12 Governing Body, 42 CFR 482.13 Patient Rights, and 42 CFR 482.21 QAPI.

We look forward to receiving your approval of this Action Plan. If you have any questions or require any further information please contact Cathy McClellan at 305-674-2555.

Thank you for your consideration in this matter.

Sincerely,

Steven D. Sonenreich

President and Chief Executive Officer

Mount Sinai Medical Center

cc: Arlene Mayo-Davis

Field Office Manager

8333 NW 53rd St. Suite 200

Miami, Florida 33166

Mount Sinai Free-Standing

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A-043 CFR(s): 482.12 A 000 **INITIAL COMMENTS** The Professional Affairs Committee (PAC) of the A 000 Board of Trustees of the Medical Center will provide oversight and accountability to ensure that patient An unannounced federal complaint survey, rights are protected, a safe environment is maintained, clear expectations for patient safety are complaint number: 2019008293, was conducted set and an effective Quality and Performance on 05/29/2019 to 05/30/2019 and 06/04/2019 at Improvement program is in place. The PAC is Mount Sinai Medical Center, which is located at compromised of several members of the Governing 4300 Alton Road, Miami, FL. 33140 to review the Board, Hospital CEO, Chief of Staff, Medical Staff Conditions of Participation: Patient Rights. Leadership, Chief Nursing Officer, Chief Medical Office, Senior Vice President of Special Services. Governing Body and Quality Assessment and Vice President of Quality. The PAC meets Performance Improvement (QAPI). monthly and reports its activities to the full Hospital Governing Board. The plan for improving the Mount Sinai Medical Center was not in processes that lead to the deficiencies cited includes compliance with the Federal Regulations at 42 how the hospital is addressing improvements in its CFR 482 requirements for Acute Care Hospitals. systems, in order to prevent the likelihood of recurrence of the deficient practice. It was identified that the hospital had multiple conflicting policies that Immediate Jeopardy was identified on 05/29/2019 required review, feedback and updates. The and ongoing at the Condition of Participation: following policies will be reviewed by PAC on the Patient Rights A-115. next scheduled meeting (6/18/19) as part of the Condition level deficiencies were identified at: overall action plan presented by the VP of Risk QAPI A-263, and Governing Body A-43. Management: Abuse, Neglect or Exploitation Policy 6/17/19 renamed to Required Reporting of Allegations/ A 043 **GOVERNING BODY** Possible Abuse, Neglect or Abandonment of CFR(s): 482.12 Patients. This Hospital wide policy defines the steps taken to report abuse, neglect or abandonment There must be an effective governing body that is attributed to either internal or external events. There legally responsible for the conduct of the hospital. is now clear expectation that the appropriate reporting bodies will be contacted, such as DCF if If a hospital does not have an organized abuse is suspected or has occurred. If the allegation governing body, the persons legally responsible involves a hospital employee and a patient, the for the conduct of the hospital must carry out the involved employee will be removed from all patient contact until the investigation is conducted. The functions specified in this part that pertain to the Sexual Assault Protocol (RAPE) – policy has been expanded to a Hospital Wide Policy and now reflects governing body ... a section on how to care for a patient after an alleged This CONDITION is not met as evidenced by: sexual assault, which includes but is not limited to, Based on record reviews, staff interviews, and the Nursing Supervisor or Charge Nurse assigning a review of policies, the governing body failed to 1:1 Patient Safety Tech or Sitter to the patient. The maintain responsibility for the conduct of the Patient Safety Tech or Sitter assigned to the patient will be the gender of the patients choice. The hospital employees and ensure the effectiveness accused employee will be immediately removed from of the person(s) responsible for the conduct of the area of the allegation and will not be able to the hospital employees resulting in an incident of return to work until cleared pending Human sexual assault involving one patient (SP #1) of 4 Resources determination.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

sh Manusement ? PI

(X6) DATE

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	sampled patients of CHIEF EXECUTIVE CFR(s): 482.12(b) The governing bode executive officer with the hospital. This STANDARD Based on record review of policies of maintain responsil effectiveness of perconduct of the hospital conduct of the hosp	(SP). (Refer to A-0057) /E OFFICER dy must appoint a chief who is responsible for managing is not met as evidenced by: review, staff interviews and the governing body failed to polity for ensure the erson(s) responsible for the epital employees resulting in an assault involving one patient	A 043 A 057	Continued from page 1	quest ar gender bereal explain the ect patient tance of at did not associated egations of tigations — d to provide f allegations an e followed ions. At the s will review the affected s hade inployee al report of ons taken ployee is dice ent the s staff which attions. etion except ince. If the work, they ine eld a huddle process of	6/13/19 6/17/19 6/17/19

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VI, Rish Mg/Mt/PI

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PRINTED: 06/10/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINA! MEDICAL CENTER MIAMI BEACH, FL 33140 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) Continue from page 2 Quality Monitoring and accountability for A-043 A 057 Continued From page 2 CFR(s): 482.12 as recommended by law enforcement. Policies listed above were approved by PAC. uploaded to Policy Stat, rolled out to staff and changes In an interview with Vice President Risk were communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log was Management on 05/29/2019 at 11:07AM revealed created to validate compliance of daily reporting. on 11/05/2018, patient complained of being Director of RM will monitor Nursing Supervisor Report sexually assaulted by a Mental Health Technician in order to complete the log on a daily basis. The log (MHT) and identified employee by name. The will include verification of the following: notification of the CEO by the VP of RM, notifying DCF, notifying the police were called and conducted an Police and documentation of DCF notification in the investigation. Arrangements were made to medical record. 3.) BH monitoring log to validate Q15 transfer patient with 2-MHT employees to the checks. This monitoring will be accomplished by doing Rape Treatment Center to be evaluated. At some unannounced spot-check visual rounding and by point, the police interviewed the employee and monitoring the camera surveillance in the nursing obtained DNA specimen from him. Investigation station real-time. This will be done by Director of BH. 4.) VP of RM will present Lessons Learned at PAC as was conducted by Risk Management, Human a result of the RCA. In addition, results of Quality Resources and the Behavioral Health Nursing Monitoring will be presented on a monthly basis until Director, all whom spoke with employee. completion of the action plan, 5.) Education Employee indicated that he was in the room only compliance of the BH General Safety Policy will be minutes. Last Wednesday, 05/22/2019, the 100% as exhibited through the sign-in sheet by hospital administration was informed that the 6/17/19. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report DNA sample taken from the patient matched the will be submitted to the PI department to show DNA taken from the employee and the employee evidence of completion for those employees who were was arrested. The following day, Thursday, not scheduled during the roll out of this education. This 05/23/2019, the Vice President Risk Management was rolled out by the Director of BH. 6.) Education and the Director Risk Management notified the compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic Joint Commission but did not notify the report by 6/17/19. Of those employees not scheduled Department of Children's and Families. The DNA during the roll-out of this education, all employees will findings were consistent with the police report, on complete the course before resuming patient care. the breast and the in the vagina. The actual This is done by the Manager of Training and results were not provided to the facility. Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show Interview with Clinical Director Behavioral Health evidence of completion for those employees who were on 05/29/2019 at 3:02PM revealed the employee not scheduled during the roll out of this education, 7.) Staff A attended a 1-day training on 05/22/2019 Compliance of the New Employee education will be

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and went to police station. This was the last day

of work for the employee. The Clinical Director

11/15/2018, to discuss mandatory education on

abuse and neglect and remind staff about not

Behavioral Health had a staff meeting on

entering patient rooms alone. Review of

Department. Facility ID: HL100034 Touthy , McCluben VP, RM & PI

documented by the Manager of Training and Development. 100% compliance will be exhibited by

signed check lists submitted to the Quality Manager.

8.) Purposeful Rounding education will be documented

by the Director of Behavioral Health. 100% compliance

will be exhibited by sign-in sheet provided to the PI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	100034		STREET ADDRESS, CITY, STATE, ZIP CODE	06	/04/2019
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A 057	D57 Continued From page 3 Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence. Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident.		A 057	Continued from page 3 9.) Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF		6/17/19
	on 06/04/2019 at 1 has not been presere report is in draft to meeting. PATIENT RIGHTS CFR(s): 482.13 A hospital must propatient's rights. This CONDITION is Based on record review of policies, the care in a safe setting right to be free from 1 (SP#1) out of 4 s	cal Director Behavioral Health 1:03AM revealed the incident ented to the Board but the be presented at the next tect and promote each s not met as evidenced by: eview, staff interviews, and he facility failed to provide ig, and ensure the patient's hall forms of (sexual) abuse in ample patients (SP). The prevent abuse resulted in an	A 115	Polices reviewed by PAC will be implement Allegations of Sexual Misconduct and Pol Investigations policy now states that a fin the investigation results and the actions to reported to the CEO by the VP of Risk Mal An email sent to clinical staff stressing the importance of timely completion of the macomprehensive Sexual Abuse Education out by the CEO. All clinical staff are expected to the training, with no exceptions, employees were on a leave of absence. Sonot complete the education could not resucare until they have completed the course Quality Monitoring and Accountability of CFR(s) 482.12 (b): 4.) Policies listed above approved by PAC, uploaded to Policy Staff to staff and changes were communicated Memo from the Chief Compliance Officer. Risk will present Lessons Learned at PAC of the RCA. In addition, results of Quality I as outlined in this plan will be presented of basis until completion of the action plan.	ice al report of iken will be nagement. e ndatory was sent ted to unless the taff that did me patient for A-057 we were , rolled out via Policy 2.) VP of as a result Monitoring	6/13/19

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A 115	employee sexually assaulting a patient. The hospital's failure to ensure patients are free from abuse, sexual assault by employees providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate corrective action on the part of the hospital. (Refer to A-0144 and A-0145) A 144 PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility failed to provide care in a safe setting, in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to ensure the employee provide care and services in a safe setting resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital. The findings include: Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified.		A 1	The Behavioral Health General Safety Policy was revised to be more specific regarding protocols for entering patient rooms. Staff was educated on the revised policy. The education and training stressed the importance of intervening if they witness actions by other staff that did not follow policy. The education and training also included the consequences associated with not following the policy. Human Resources has developed a policy to delineate the process for employees who are under investigation by law enforcement. Employees under police investigation will be reviewed by the Service Line Vice President, CNO, CMO (as appropriate) and a membe of Human Resources to make a joint decision on the appropriateness of the employee returning to work. A final report of the actions taken will be reported to the CEO by the VP of Risk Management. In addition to Sexual Abuse Education as described in this CAP, it has been added to New Employee Orientation. The orientation checklist for New Employee Orientation was revised to validate that staff understand the definition of abuse, duty to report and professional behavior that is expected. The Behavioral Health Charge Nurse will ensure that all staff present on the unit are the appropriate/necessary staff for the shift. Staff not assigned to the unit will be not be allowed onto the floor unless performing assigned duties		6/13/1 6/17/1	
A 144			A 1-			6/14/19	
				requiring their presence. Quality Monitoring and Acc CFR(s): 482.13 1.) A Risk M created to validate compliance. Director of RM will monitor NU in order to complete the log of will include verification of the the CEO by the VP of Risk Middle DCF, notifying the Police and notification in the medical recommonitoring log to validate Q15 monitoring will be accomplish unannounced spot-check visus monitoring the camera surveil station real-time. This will be as a result of the RCA. In add Monitoring as outlined in this parenothly basis until completic	lanagement log was e of daily reporting. ursing Supervisor Report in a daily basis. The log following: notification of anagement, notifying documentation of DCF ord. 2.) BH created a checks. This ed by doing lal rounding and by lance in the nursing done by Director of BH. soons Learned at PAC lition, results of Quality plan will be presented or		

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The employee returned to direct patient care in

the behavioral health department (to include the

inpatient unit and the emergency department

psyche area) pending the results of the DNA

VP, Rial mant's PI

or Charge Nurse assigning

organization-wide policy. The policy was updated to include a section on how to care for a patient who

includes, but is not limited to, the Nursing Supervisor

states they are a victim of sexual assault which

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	IAME OF PROVIDER OR SUPPLIER MOUNT SINAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 ALTON RD MIAMI BEACH, FL 33140		04/2019
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A 145	11/30/2018 revealed 11/07/2018, (date of suspended unpaid returned to regular 11/09/2018. The facility's admin 05/22/2019 that the patient matched the employee and the effective with Behard 05/29/2019 at 3:021 assigned to psyche role, the tech assist documentation and ED to the inpatient in the ED, staff is assunit. The Behavioral Hear "Suspected Patient (revised date: 05/20 admitted to the Dep Psychiatry/Behavior protected from abus physical roughness, harassment, DEFIN Sexual abuse included."	nches for period 11/01/2018 - d patient worked Wednesday, if incident). Employee was on Thursday, 11/08/2018, and work schedule on Friday, istration was notified on DNA sample taken from the DNA taken from the EDNA taken from the EMPLOYEE WAS INTERESTENDED. Invioral Health Unit Director on PM revealed employee was intake unit in the ED. In this ed with admission transported patients from the psyche unit and if it is not busy sked to help in the inpatient with policy with the title: Abuse/Neglect, 16.4.021," Interest all patients artment of ral Health Unit shall be see of any kind including werbal threats or seles any sexual overture made or physical irrespective of the be involved in it. FREE FROM ENT	A 144	Continue from page 6	ned to the Patient noice. If it is issed employee will area of the turn to work until a determination. Ince of intervening that did not follow stated with not ped a policy to s who are under under police to the Service Line propriate) and a sion on the aturning to work. A be reported to the Abuse Education Orientation. The polyal transport of the control of the co	6/17/19

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A 145	This STANDARD Based on record and review of policithe patient's right (sexual) abuse in patients (SP). The patients are free from a findings of imm 05/29/2019 and or is likely to result in impairment, or dealimmediate correctionspital. The findings include The Census: on 11-11:00 PM shift, was Clinical Record reviewedled she arriver Room) on 11/05/20 Baker Acted	e right to be free from all forms sment. is not met as evidenced by: review and staff interviews, cies, the facility failed to ensure to be free from all forms of 1 (SP #1) out of 4 sample hospital's failure to ensure rom abuse (sexual assault) by iding care and services resulted mediate jeopardy beginning on agoing, creating a situation that serious injury, harm, ath to patients and requires on action on the part of the	A 145	4.) Director of Risk Management will aud reporting process outlined in policy for all of sexual misconduct. This audit will assu appropriate 1:1 observation was assigned accused employee was suspended/remo was called and the Police were notified. For data will be submitted to the Quality Mishow evidence of 100% compliance. A-145 CFR(s): 482.13(c)(3) The Emergency Department Sexual Assa (Rape) has been revised and adapted as organization-wide policy. The policy was include a section on how to care for a pat alleged sexual assault which includes, but limited to, the Nursing Supervisor or Charassigning a 1:1 Patient Safety Tech or Sitter the Patient will be the gender of patient CP Policy Memo was sent out to staff alerting new changes to the policy. The accused obe immediately removed from the area of allegation and will not be able to return to cleared pending Human Resources deten During Shift Hand-Off, staff will communic wishes of the patient should they request no exposure to a particular gender while to observation. A flag was created to confirm reporting was completed when a sexual mevent is entered into the internal incident eystem. The Director of RM will run month ensure all allegations of sexual misconduct reported to the governing board at the PA Review of the Nursing Supervisor report to Director of RM will ensure that all allegation in the shift. Staff not assigned staff present on the unit are the approping excessary staff for the shift. Staff not assignit will be not be allowed onto the floor unperforming assigned duties requiring their	allegations are that the did, that the did, that the ved, DCF four months anager to a sulf Protocol an changed to ient after an t is not ge Nurse the to the assigned to noice. A in them of the employee will the work until mination. The individual or under 1:1 in DCF i	6/17/19

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Event ID: BILS11

BILS11 Facility ID: HL100034

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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
A 145	Continued From page 8 by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended		A 145	Continued from Page 8		6/17/19		
-	Review of Police R 11/07/2018 at 7:30			Nursing Leaders to explain the process and what their role is when an allegation their attention. The Nursing Supervisor that the proper documentation in the mareflects the date/time/follow up of the pande to report the incident. Nursing Supervisor	s of reporting on is brought to will assure edical record hone call	6/14/19		
	reference to a fema employee of the ho will. Officers made stated that one of t her inappropriately	ale patient accusing a male ospital touching her against her contact with complainant who he male employees touched in various places about her	-	also document the reporting of the incic Nursing Supervisor Report, which will s double-check for RM to follow up with, an analysis of the event with staff from reviewed the surveillance video. A sun lessons learned will be disseminated to	dent on the serve as a RM conducted BH and nmary of Behavioral			
	(later to be known a and began a conve eating his dinner. S conversation, the e	patient, the male employee as Staff-A) came into her room ersation with her, while he was cometime during the employee approached her and st. Patient then stated that				Health staff, Nursing leadership and PA "Purposeful Rounding" education was or re-educate staff on the appropriate protoconducting rounds or having interaction patients. Longer conversations or 1:1 s done in the hallway or in an area where surveillance. Staff who do not complete	conducted to tocol when as with upport will be there is video	6/17/19
	employee took her hand on his penis.	hand and forcefully placed her The employee left the room ient then stated that the		education due to scheduling or leave cannot resume patient care until they have completed the course. Quality Monitoring and Accountability for A-145 CFR(s): 482.13(c)(3) 1.) BH created a monitoring lot to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 2.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the Nett-earning electronic report by 6/17/19. Of those employees no				
	15-20 minutes later by kissing and care her inappropriately hand on her vagina a picture of the pati dressed before leave	ck to the room approximately and made another advance essing her breast then touching by placing his (wet/saliva). The employee allegedly took ent while she was getting ving the room. Officers made uployee who admitted to having						
	a conversation with physical contact with Review of Staff-A ct 11/01/2018 to 11/30 Wednesday, 11/07/ returned to regular	the patient, but denied any		scheduled during the roll-out of this edu employees will complete the course bef patient care. This is done by the Manag and Development. Evidence of complia submitted to the PI department by 6/17/ report will be submitted to the PI depart evidence of completion for those employ were not scheduled during the roll out of education.	cation, all ore resuming er of Training ince will be 19. A weekly ment to show yees who			

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Cathy . McCluber VP, Rich Mant; PI

PRINTED: 06/10/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 06/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		04/2015
MOUNT S	NAI MEDICAL CENTER			4300 ALTON RD MIAMI BEACH, FL 33140		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 145	Review of 4 Warner Wing) video footage 06/04/2019 revealed exited the room of SI following times: 1. Staff-A Entered: 7:07:45 PM 2. Staff-A Entered: 7:11:06 PM 3. Staff-A Entered: 7:14:20 PM 4. SP #1 in hallway room at 7:26:04 PM 5. Staff-A in hallway room at 7:31:38 PM 6. SP #1 enters roof follows, Staff-A Exiter 7. SP #1 out of root to room at 7:32:26 Pl 8. Staff-A walks do follows at 7:33:20 Pl 9. SP #1 enters roof 10. Staff-A Entered: 7:35:23 PM 11. Staff-A Entered: 7:35:58 PM 12. SP #1 out of roof employees and nursi room at 7:41:35 PM 13. SP #1 observed times and pacing the 7:55 PM 14. Police observed In an interview with 1 Management on 05/2 on 11/05/2018, paties sexually assaulted by	Southeast Corridor (Female of Staff-A and SP #1 on that Staff-A entered and P #1 on 11/07/2018 at the 7:04:40 PM, Staff-A Exited: 7:08:23 PM, Staff-A Exited: 7:12:47 PM, Staff-A Exited: 7:12:47 PM, Staff-A Exited: 7:12:47 PM, Staff-A Exited: 7:12:47 PM and returns to y speaking with SP #1 at pm at 7:31:44 PM and Staff-A ed: 7:32:16 PM m at 7:32:22 PM and returns M m at 7:32:22 PM and returns M m the hallway and SP #1 M pm at 7:33:40 PM pm at 7:33:47 PM, Staff-A Exited: 7:35:27 PM, Staff-A Exited: 7:35:27 PM, Staff-A Exited: 1 m at 7:37:00 speaks with ng station and returns to 1 in and out of room multiple hallway from at 7:42 PM to 1 at 8:49:22	A 14	3.) Purposeful Rounding educated documented by the Director of 100% compliance will be exhib provided to the PI Department. Management will audit the repoutlined in policy for all allegatismisconduct. This audit will assuappropriate 1:1 observation was accused employee was susper was called and the Police were months of data will be submitted Manager to show evidence of 1	Behavioral Health. ited by sign-in sheet 4.) Director of Risk orting process ons of sexual ure that the as assigned, that the nded/removed, DCF ontified. Four ed to the Quality	

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Cathy J. Mk Clubon VP, Rish Mgmt & PI

PRINTED: 06/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 06/04/2019
	NAME OF PROVIDER OR SUPPLIER MOUNT SINAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 4300 ALTON RD MIAMI BEACH, FL 33140	ODE
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
A 145	investigation. Arratransfer patient wi Rape Treatment C point, the police in obtained DNA spewas conducted by Resources and the Director, all whome Employee indicate minutes. Last Weethospital administration DNA sample taken DNA taken from the was arrested. The 05/23/2019, the V and the Director F Joint Commission Department of Ch findings were consthe breast and the In an interview wit 05/29/2019 at 12: stated the allegation had history of reponsiture and from the until the results of In an interview wit telephone on 05/2 that nurse was in was yelling and maped me. Nurse distened to the contalked and the patthe mental health	and conducted an ingements were made to the 2-MHT employees to the center to be evaluated. At some sterviewed the employee and scimen from him. Investigation Risk Management, Human is Behavioral Health Nursing spoke with employee. It is that he was in the room only disesday, 05/22/2019, the action was informed that the inform the patient matched the inform the patient matched the information of the employee and the employee infollowing day, Thursday, it is president Risk Management thisk Management notified the but did not notify the information of the same in the vagina. In Director Risk Management on the vagina. In Director Risk Management on the vagina. In Director Risk Management on the same in the vagina. In Crimary Nurse) Staff-D via 19/2019 at 3:25 PM revealed the DNA testing. In (Primary Nurse) Staff-D via 19/2019 at 3:25 PM revealed the hallway when the patient entioned that the Spanish guy calmly approached patient and inplaint. Nurse and patient ient gave the description that technician had entered the did not go into detail about	A 1-	45	

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Carthy McCellan

UP, Rish Mant's PI

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/04/2019
	NAME OF PROVIDER OR SUPPLIER MOUNT SINAI MEDICAL CENTER			EET ADDRESS, CITY, STATE, ZIP CODE 0 ALTON RD 1MI BEACH, FL 33140	1 06/04/2019
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	telephone on 5/29 the patient was by The charge nurse Behavioral Health nurse to call the pe employee was ass emergency depart had brought 5 adm department to the the 3P-11P shift. The Behavioral He "Victims of Abuse, (revised date: 05/2 department of psyc strive to identify, to abuse, assault or r not limited to, adult domestic violence, molestation. Staff if department will rec in identifying possii neglect. 2. Any em reasonable cause or disabled adult is abandoned, neglec immediately report to the Director. Dire	arge Nurse) Staff-E via /2019 at 3:35PM revealed that the room door complaining, notified the Clinical Director whom instructed the charge blice department. The signed to work in the ment psyche intake area and hissions from the emergency behavioral health unit during alth policy with the title: Assault or Neglect, 16.4.008," 019) states that the chiatry/behavioral health shall eat and report all cases of heglect. This included, but is and elder abuse and neglect, victims of crime and sexual Education: 1. All staff in the reive initial and ongoing training ble victims of abuse, assault or ployee who knows, or has to suspect that an aged person or has been abuses, sted, or exploited, shall such knowledge or suspicion ector or designee must notify Hotline of the Department of	A 145	DEFICIENCY)	
-	"Suspected Patient	alth policy with the title: Abuse/Neglect, 16.4.021," 019) states all patients			

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Event ID: BILS1

Facility ID: HL100034

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Cathy J. McClellan

Vt, RM JEI

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		& MEDICAID SERVICES			OMB N	IO. 0938-039	
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED C	
NAME OF D	DOMEST OF SUREY ISS	100034	B. WING		0	6/04/2019	
	PROVIDER OR SUPPLIER	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MIAMI BEACH, FL 33140				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 145	Psychiatry/Behavior protected from abust physical roughness harassment, DEFI Sexual abuse inclusto a patient verbal patient's willingness. The Behavioral Her Reporting: External 16.4.015, (revised of protecting).	oral Health Unit shall be use of any kind including so, verbal threats or NITION: SEXUAL ABUSE - udes any sexual overture made or physical irrespective of so to be involved in it. alth policy title:d "Abuse I and Internal Events, date: 06/2016) states that the	A 14	Risk Management conducted an analy event with staff from BH and reviewed surveillance video. Further action above beyond as described in this CAP will be developed. A summary of lessons lead disseminated to Behavioral Health stalleadership and PAC. This event was self-reported to The Jocommission. Quality Monitoring and Accountabili A-263 CFR:482.21	I the ove and oe rned will be ff, Nursing oint	6/13/19 5/23/19	
A 263	The Behavioral Health policy title:d "Abuse Reporting: External and Internal Events, 16.4.015, (revised date: 06/2016) states that the incident shall be reported to the Abuse registry at 1-800-96-ABUSE immediately after the Chairman of the Department and/or Nurse Director are informed of the matter. Documentation in the patient's medical record shall include the time of call, supportive information, and any follow-up contact. A 263 QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.		A 263	1. Director of Risk Management will au reporting process outlined in policy for allegations of sexual misconduct. This assure that the appropriate 1:1 observ assigned, that the accused employee suspended/removed, DCF was called Police were notified. Four months of d submitted to the Quality Manager to st evidence of 100% compliance. 2. Polic above were approved by PAC, upload Stat, rolled out to staff and changes we communicated via Policy Memo from the Compliance Officer. 3. A Risk Manage was created to validate compliance of reporting. Director of RM will monitor in Supervisor Report in order to complete a daily basis. The log will include verified the following: notification of the CEO be Risk Management, notifying DCF, notified and documentation of DCF notified the medical record. 4.) VP of Risk will be sexually be documented by the Manager of 5.) Compliance of the New Employee of and Development. 100% compliance of the Employee education will be documented Manager of Training and Development compliance will be exhibited by signed submitted to the Quality Manager.	all audit will ation was was and the ata will be now cies listed ed to Policy ere he Chief ement log daily lursing at he log on cation of y the VP of fying the fication in present if the RCA. ducation Training will be ed to the e New ed by the 100%		

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Carty Tille Cullar

VP, RMZEI

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034		IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		LETED C
	NAME OF PROVIDER OR SUPPLIER MOUNT SINAI MEDICAL CENTER SUMMARY STATEMENT OF REFIGIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 ALTON RD MAMI BEACH, FL 33140	1 06/	04/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 283	Based on record review of policies, and Performance develop, identify and have an Actio improvement; and safety as a result involving a patient (SP). (Refer to A-0283 a QUALITY IMPRO CFR(s): 482.21(b) (b) Program Data (2) [The hospital a] (ii) Identify oppichanges that will left (1) The hospital inperformance improvement (ii) Consider the severity of problem quality of care. (3) The hospital imperformance improvementing thospiementing thospiemeasure its successive and Activity of problementing thospiemeasure its successive and Performance improvementing thospiemeasure its successive and Performance improvementing thospiementing thospiementing thospiemeasure its successive and Performance improvementing thospiementing thos	is not met as evidenced by: review, staff interviews, and the facility Quality Assessment Improvement Program failed to opportunities for improvement in Plan aimed at performance provide clear expectations for of an incident of sexual assault (SP #1) of 4 sampled patients and A-0286). VEMENT ACTIVITIES (2)(ii), (c)(1), (c)(3) must use the data collected to - contunities for improvement and lead to improvement. ties must set priorities for its ovement activities that— gh-risk, high-volume, or		Continue from page 13 7.) Purposeful Rounding education will documented by the Director of Behavior 100% compliance will be exhibited by sprovided to the PI Department. A-283 CFR(s): 482.21(b)(2)(ii), (c)(1), (c) RM conducted an analysis of the event BH and reviewed the surveillance video of lessons learned will be disseminated Health staff, Nursing leadership and PA and Neglect Policy was updated and rechecklist attached to guide Nursing Leato handle and report these allegations. describes how and when to contact RM Nursing Director conducts monthly envisafety rounds through the unit. This dat to the Behavioral Health Patient Safety and then presented at the Organization Safety Committee. The Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral Health units. Risk Management reviews that are reported in the Behavioral	ral Health. ign-in sheet c)(3) with staff from b. A summary to Behavioral AC. The Abuse ow includes a iders on how The checklist I. The BH ironmental a is presented Committeewide Patient the Behavioral s all incidents the unit. Follow- in the incident t video ely following by A-283 1.) Policies ploaded to ges were the Chief the	6/13/19

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Cathy Ti McCellas VP, RM; &I

CENTERS FOR MEDICARE & MEDICAID SERVICES.

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		A MILDIOAID SERVICES			OMB NO). 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		PLETED
		100034	B. WING			C 04/2040
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	04/2019
MOUNTS	MOUNT SINAI MEDICAL CENTER			4300 ALTON RD MIAMI BEACH, FL 33140		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 283	This STANDARD—Based on record review of policies to implement the Quarent Performance Improperformance improsexual assault incisampled patients (The findings included The Census: on 11—11:00PM shift, was clinical Record reviewealed she arrived Room) on 11/05/20 Baker Acted on 11/1/100PM shift, was the lath Unit on 11/100PM shi	is not met as evidenced by: review, staff interviews, and the facility failed to fully ality Assessment and overnent Action Plan aimed at overnent as a result of an a dent involving 1 (SP #1) of 4 SP). de: 1/07/2018, for the 3:00PM s 21 patients with 8 females. riew of sample patient (SP) #1, ed in the ER (Emergency 19 at 10:22 PM. She was r/06/2018 at 12:01PM for pressive disorder/suicidal admitted to the Behavioral 106/2018 at 11:00 AM. ral Health Nursing Notes of the aff-D, documented on 2 PM that at 7:40 PM patient ared nurse on duty to complain sexually harassed by nental health technician in her nurse and attending aware. Police notified. by law enforcement for ranges to be transported to rat [named] Hospital for mmended by law enforcement. I Vice President Risk 10/29/2019 at 11:07AM revealed	A 28	Continue from page 14	s of Quality thly basis until ation compliance a 100% gn-in sheet by e submitted to to show oyees who were deducation. This Education ation will be 90% uning electronic to show oyees who were deducation. This Deducation ation will be 90% uning electronic to to scheduled employees will bet be exployees to the PI t will be t evidence of the properties to we will the properties to the properties to we will the properties to the properties the	
ODIA ONE OFF		ent complained of being				

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Cottly & Mc Cellan VP, RM & PI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER		STR 4300	EET ADDRESS, CITY, STATE, ZIP CODE D ALTON RD MI BEACH, FL 33140	06/04/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
A 283	(MHT) and identification police were called investigation. Arrar transfer patient wit Rape Treatment C point, the police introbtained DNA special was conducted by Resources and the Director, all whom Employee indicate minutes. Last Wed hospital administration DNA sample taken DNA taken from the was arrested. The 05/23/2019, the Vicand the Director Ri Joint Commission I Department of Chill findings were consthe breast and the results were not profit of the minutes. Interview with Clinion 05/29/2019 at 3 Staff A attended a rand went to police of work for the emple Behavioral Health I 11/15/2018, to discabuse and neglect entering patient roc Behavioral Health (documented on 11/Findings/Conclusio alone when doing in the police of work for conclusional decimal for the minutes.	by a Mental Health Technician ed employee by name. The and conducted an ingements were made to the 2-MHT employees to the enter to be evaluated. At some terviewed the employee and cimen from him. Investigation Risk Management, Human e Behavioral Health Nursing spoke with employee d that he was in the room only inesday, 05/22/2019, the stion was informed that the from the patient matched the employee and the employee following day, Thursday, ce President Risk Management isk Management outfied the but did not notify the dren's and Families. The DNA istent with the police report, on in the vagina. The actual ovided to the facility. Cal Director Behavioral Health 102PM revealed the employee 11-day training on 05/22/2019 station. This was the last day poloyee. The Clinical Director and a staff meeting on uses mandatory education on and remind staff about not oms alone. Review of General Staff Meeting Agenda	A 283		

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Country McCluber VP, RM; PI

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	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		DISTRUCTION	(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER	ER	4300	EET ADDRESS, CITY, STATE, ZIP CODE ALTON RD MI BEACH, FL 33140	06/04/2019
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
A 283	in room, this is register best way to protect possible physical in Recommendations or 1:1 support should dining rooms (any activity, get second Non-behavioral her patients. Accompande Department of Psy Sign-in sheet reversignatures out of a in attendance. No action plan was immore that the policy titled: 'Occurrences, 1.28 states that sexual is defined as noncinvolving a patient member, or other por on the premises vaginal or anal perpatients sex organishand, sex organ of following must be presented above obtained by the hounconsented sexual perpetrator that sexual perpetrato	gardless of gender. This is the at yourself from allegations and	A 283		

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Carty McCellan VP, RM SPI

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/10/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 100034 B. WNG 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** A-286 CFR(s): 482.21(a), (c)(2), (e)(3) A 286 Continued From page 17 A 286 A 286 PATIENT SAFETY A 286 Risk Management conducted an analysis of the CFR(s): 482.21(a), (c)(2), (e)(3) event with staff from BH and reviewed the surveillance video. Further action above and (a) Standard: Program Scope beyond as described in this CAP will be developed. 6/13/19 (1) The program must include, but not be limited A summary of lessons learned will be disseminated to, an ongoing program that shows measurable to Behavioral Health staff, Nursing leadership and PAC. Quality Monitoring as a result of this analysis improvement in indicators for which there is will be rolled out and shared as described above. evidence that it will ... identify and reduce medical errors. The Abuse and Neglect Policy was updated and (2) The hospital must measure, analyze, and now includes a checklist attached to guide Nursing 6/17/19 track ...adverse patient events ... Leaders on how to handle and report these allegations. The checklist describes how and when to contact Risk Management. (c) Program Activities (2) Performance improvement activities must The Behavioral Health Nursing Director conducts track medical errors and adverse patient events, monthly environmental safety rounds through the analyze their causes, and implement preventive unit. This data is presented to the Behavioral Health actions and mechanisms that include feedback Patient Safety Committee and then presented at the and learning throughout the hospital. Organization-wide Patient Safety Committee. The 6/17/19 Behavioral Health Patient Safety Committee also debriefs and develops action plans for notable (e) Executive Responsibilities, The hospital's incidents occurring in the Behavioral Health units. governing body (or organized group or individual who assumes full legal authority and responsibility An education titled "Purposeful Rounding" was for operations of the hospital), medical staff, and conducted to re-educate staff on the appropriate administrative officials are responsible and protocol when conducting rounds or having interactions with patients. Longer conversations or accountable for ensuring the following: ... 6/17/19 1:1 support will be done in the hallway or in an area (3) That clear expectations for safety are where there is video surveillance. Staff who do not established. complete this education due to scheduling or leave This STANDARD is not met as evidenced by: cannot resume patient care until they have Based on record review, staff interviews, and completed the course. review of policies, the facility governing body Quality Monitoring and Accountability for A-286 failed to assume responsibility in setting clear CFR(s): 482.21(a), (c)(2), (e)(3) 1.) Policies listed expectations for safety as a result of an incident above were approved by PAC, uploaded to Policy of sexual assault involving a patient (SP #1) of 4 Stat, rolled out to staff and changes were sampled patients (SP). communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log

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The findings include:

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Carty , McChilas

Clinical Record review of sample patient (SP) #1,

VP, Risk ingut: PI

daily basis.

was created to validate compliance of daily reporting. Director of RM will monitor Nursing

Supervisor Report in order to complete the log on a

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		& MEDICAID SERVICES			OMB No	O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
NAME OF B	IE OF PROVIDER OR SUPPLIER		D. 111110_	100	06	/04/2019
	INAI MEDICAL CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MIAMI BEACH, FL 33140		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 286	Continued From page 18			Continue from page 18		
		ed in the ER (Emergency	A 28	The log will include verification of the following:		
	Room) on 11/05/20	019 at 10:22 PM. She was				
	Baker Acted on 11	/06/2018 at 12:01PM for		notification of the CEO by the VP of	RM, notifying	
		pressive disorder/suicidal		DCF, notifying the Police and docum notification in the medical record. 3.)	BH monitoring	
	ideation Showes	admitted to the Behavioral		log to validate Q15 checks. This mor	itoring will be	
		06/2018 at 11:00 AM.		accomplished by doing unannounced	spot-check	
	visual rounding and by monitoring the cam				e camera	
	Review of Behavio	oral Health Nursing Notes of the		surveillance in the nursing station re-	al-time. This will	
		taff-D, documented on		be done by Director of BH. 4.) VP of RM will preser Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring will be presented on a monthly basis until completion of th action plan. 5.) Education compliance of the BH General Safety Policy will be 100% compliance as exhibited through the sign-in sheet by 6/17/19.		
		2 PM that at 7:40 PM patient				
	approaches registe	ered nurse on duty to complain				
	that she has been	sexually harassed by				
	emergency room n	nental health technician in her				
	room 474. Charge	nurse and attending		Evidence of compliance will be subm		
	psychiatrist made	aware. Police notified.		department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. This was rolled out by the Director of BH. 6.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming		
	Evidence collected	by law enforcement for				
	analysis. Patient a	rranges to be transported to				
	rape trauma center	r at [named] Hospital for				
	evaluation as recor	mmended by law enforcement.				
	In an interview with	Vice President Risk				
-	Management on 05	5/29/2019 at 11:07AM revealed				
	on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician			patient care. This is done by the Manager of Train and Development. Evidence of compliance will be		
	(MHT) and identifie	(MHT) and identified employee by name. The		submitted to the PI department by 6/	17/19. A weekly	
	police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee			report will be submitted to the PI department to she evidence of completion for those employees who		
				were not scheduled during the roll ou	t of this	
				education. 7.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 8.) Purposeful Rounding education will be documented by the Director of Behavioral		
-				Health. 100% compliance will be exhi		
	Employee indicate	spoke with employee		sheet provided to the PI Department.		
	minutes I set Med	that he was in the room only				
	hospital administrat	nesday, 05/22/2019, the				
	hospital administration was informed that the DNA sample taken from the patient matched the		3			
	DNA taken from the	employee and the employee				
	DI III CAROLLI I CHI	employee and the employee				

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Event ID: BILS11

Facility ID: HL100034

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Carty J. No. Cellan

VP, Rich Mant & EI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DA	(X3) DATE SURVEY COMPLETED C	
	ER OR SUPPLIER		ST 43	REET ADDRESS, CITY, STATE, ZIF 00 ALTON RD AMI BEACH, FL 33140		06/04/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
was 05/2 and Joir Dep find the rest Inte on 0 Star and of w Beh 11/1 abut ente Beh doc Find alor duti in ro bes pos Rec or 1 diniii activ Non patii Dep Sigr sign in at	23/2019, the Vill the Director Report of Commission partment of Chings were considered and the control of the c	following day, Thursday, ce President Risk Management isk Management notified the but did not notify the Idren's and Families. The DNA sistent with the police report, on in the vagina. The actual rovided to the facility. Ical Director Behavioral Health 1:02PM revealed the employee 1-day training on 05/22/2019 station. This was the last day polyee. The Clinical Director had a staff meeting on cuss mandatory education on and remind staff about not poms alone. Review of General Staff Meeting Agenda 1/15/2018 revealed cons: Only enter patient room rounds or quickly completing of have 1:1 conversations alone ardless of gender. This is the a yourself from allegations and	A 286				

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Event ID; BILS11

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Cotthy J. McCluba

VP, Rush Mant; PI

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 100034 B. WNG 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 286 Continued From page 20 A 286 Occurrences, 1.28.026," (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.

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Facility ID: HL100034

If continuation sheet Page 21 of 21

Cathy J. We Clillan

VPRMGPI

6-17-19

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